your health
NETWORK
A NEWSLETTER FOR ALL STATE GROUP INSURANCE PROGRAM PARTICIPANTS
July 2007 Volume 15, Number 1

inside

Long-Term Care Insurance

State Plan Only

Long-term care insurance coverage is available to active employees, their eligible dependents, retirees, parents and in-laws. The program is an optional plan administered by MedAmerica Insurance Company, a company dedicated exclusively to the provision of long-term care insurance. Long-term care insurance benefits cover services required by individuals who are no longer able to care for themselves without the assistance of others. The natural aging of individuals or a serious debilitating illness often brings on this need.

Long-term care insurance does not pay medical bills — that's the purpose of health insurance or Medicare. Long-term care insurance also does not replace income — continuing income is provided by a retirement plan, disability coverage or social security. What long-term care insurance does do is cover services associated with daily activities of living to help you keep your independence and stay in control of your care.

Services covered under this plan include nursing home care, assisted living, home health care, home care and adult day care. Benefits are available through different options based on a daily benefit amount ($100, $150 and $200) for either a three-year or five-year coverage period. Benefits are also available with or without inflation protection. Since long-term care covers services often required of the elderly, premiums are based on the age of the insured at the time of enrollment. Therefore, the younger you are when you apply, the lower your premium will be. Detailed premium information is available on our website at www.state.tn.us/finance/ins/.

New employees have 60 days from their date of employment to enroll in this coverage on a guaranteed issue basis. Existing employees and their eligible family members may enroll by undergoing medical underwriting. And, unlike the other coverages offered through the state group insurance program, eligible individuals may apply for coverage at any time and do not need to wait for the annual enrollment transfer period held during the fall. As with other optional insurance products, the premium for this coverage is the full responsibility of the participant. No support is provided by the employing agency.

Please visit www.ltc-tn.com or call MedAmerica toll-free at 1.866.615.5824 for more information.

Cover Tennessee Insurance Initiative

In 2006, Governor Phil Bredesen announced a new initiative to provide health coverage options for uninsured Tennesseans. The program, called Cover Tennessee, is administered by the Division of Insurance Administration and extends coverage to uninsured children, chronically ill adults and uninsured working Tennesseans. These programs, which began first quarter 2007, are not part of the public sector plans provided by the state group insurance program. A brief description of each Cover Tennessee program follows.

AccessTN

AccessTN is a comprehensive health insurance plan for seriously ill adults who are uninsurable due to an existing medical condition. There is no income determination to apply and premium assistance is available to those individuals with a household income below 250 percent of the federal poverty level. Individuals cannot have access to insurance at the time of application and there is a requirement that applicants may not have had insurance coverage during the past six months.

CoverKids

CoverKids offers comprehensive health coverage to low income, uninsured children in Tennessee, age 18 and under, and pregnant women. It is a State Children's Health Insurance Program (SCHIP), which is a partnership between the federal and state governments. In accordance with federal guidelines, CoverKids applicants must first be screened for eligibility for TennCare and to determine if they have access or are enrolled in a State Health Benefit plan due to a parent or guardian's employment. Federal guidelines prohibit children of state employees and K-12 teachers from participating in this coverage. Additionally, the child may not have had insurance coverage during the past three months to qualify.

CoverRx

CoverRx offers access to affordable medications to low income Tennesseans who do not have prescription drug coverage. This includes TennCare, Medicare or employer-sponsored drug coverage. Participants do not pay a monthly premium to participate, but copayments are required for prescriptions based on income guidelines.

CoverTN

CoverTN partners the state, private employers and individuals to offer guaranteed affordable basic health coverage for employees of Tennessee's small businesses. Businesses with 25 or fewer full-time employees within a designated median wage may apply for approval to offer this coverage. There is also a requirement that the business may not have offered health coverage to employees within the past six months for which they paid at least 50 percent of the monthly premium.

More Information

If you know of someone who could benefit from one of these programs, please encourage them to visit www.covertn.gov or call 1.866.CoverTN for eligibility and enrollment information.

Disease Management Programs

Your health is too important to leave to chance and taking an active role in your own health can have a positive impact on many other aspects of your life. Chronic health conditions, when not kept under control, can lead to serious health complications — but they don't have to.

Disease management programs help put you in control of your disease. They seek to educate you on your condition and provide support to keep that condition under control. They also provide the missing link between patient and doctor — helping individuals with a chronic illness lead more productive lives. Disease management provides a proactive approach to controlling health costs. The aim is to reduce hospitalization and emergency room visits while enhancing overall health.

Our contracted health vendors complete an analysis of claims data to identify eligible members. This information is maintained through a strict confidentiality policy. If analysis of claims information shows that you may have been diagnosed with one of the chronic diseases covered under the program, you will receive an introductory letter at your home address. This letter is followed by a welcome call. Both Cigna and United administer their disease management programs internally, while BlueCross BlueShield partners with LifeMasters to offer the Healthy Focus program.

Registered nurses and health educators can provide members with the coaching, education and support necessary to properly monitor and manage their condition on a daily basis. While participation in these programs is on a voluntary basis, if you are identified as having one of these chronic health conditions, please consider participating. It's your health — it's your choice.

	BlueCross PPO	Cigna POS	Cigna HMO	United HMO
Asthma	✓			✓
Congestive Heart Failure	✓	✓	✓	✓
Coronary Artery Disease	✓	✓	✓	
Chronic Obstructive Pulmonary Disease	✓	✓	✓	
Diabetes	✓	✓		✓

notable

During the year 2007, several drugs will come off patent and new generic equivalents will become available. These include Norvasc, one of the leading antihypertensive drugs dispensed in the US; Toprol XL, the third most frequently dispensed drug in the US in 2006 used to treat high blood pressure, chest pain and heart failure; Ambien, the number one dispensed insomnia medication nationwide; and Lamisil Tablet, a widely prescribed antifungal medication. This means that lower cost generic equivalent drugs will become available. We will be working with our claims administrators in developing a plan to notify affected plan members.

Please be advised that for services to be covered under your health insurance, they must be medically necessary. Having a physical for the purposes of playing a sports event or attending camp are not covered expenses.

To order additional or replacement insurance ID cards, please call the claims administrator for your healthcare option. Each insurance company also offers the ability to order cards online via the internet. For a complete list of website links, please visit the Division of Insurance Administration's website at www.state.tn.us/finance/ins/.

When adding or canceling coverage for a dependent, please remember to do so in a timely manner. To add coverage for a newly acquired dependent, an application must be completed within 60 days of the date a dependent is acquired. When you request cancellation, a dependent's coverage will terminate on the last day of the month in which the dependent loses eligibility.

State Insurance Committee Election Results

The authorization for providing group insurance benefits for public officers, state, local education and local government employees and retirees is found in Chapter 27 of Title 8, Tennessee Code Annotated. The benefit plans authorized by this legislation are governed separately by three committees identified as the State, Local Education and Local Government Insurance Committees. Each of these committees represents the interests of the employer and their employees in financially separate benefit plans.

The membership of the State Insurance Committee provides for the selection of two state employee representatives. The Division of Insurance Administration recently conducted an election for these two representatives to serve a term of office beginning July 1, 2007, and ending June 30, 2010. All state employees enrolled in health coverage through the State Group Insurance Program are eligible to vote for the two candidates of their choice.

Based on the results of this year's election, incumbent committee member Tom Spillman with the Department of Health will continue to serve on the committee for the next three years. Newly elected to the committee is Tim Poole with The Tennessee Wildlife Resources Agency. The committee is pleased that Mr. Spillman will continue in his position representing the interests of state employees and welcomes Mr. Poole to this new role.

Annual Dependent Eligibility Verification

Unmarried children between the ages of 19 and 24 are eligible for coverage on the state-sponsored insurance plans as long as they are full-time college students or claimed on your federal income tax return. Additionally, disabled children who are unmarried may be covered as long as they are insured on the plan prior to their 24th birthday, remain disabled and are approved by the claims administrator prior to their 24th birthday.

Annually, the state group insurance program requires the various medical insurance companies to verify that covered dependent children between 19 and 24 still meet the criteria for eligibility. This request for verification will be sent to your home address in the form of a questionnaire. They are typically sent during February and March.

Based on the results of this year's verification, over 1,500 dependents were terminated from coverage due to failure of the parent to respond to the request for information. Those terminated due to no response will be required to show proof of eligibility to reinstate coverage on the dependent child.

As the policy holder, it is your responsibility to ensure that only those dependents that are eligible for coverage are listed.

As the policy holder, it is your responsibility to ensure that only those dependents that are eligible for coverage are listed. If you are unsure of the dependents currently listed on your policy, please call your agency insurance preparer. All claims paid for ineligible dependents will be recovered from the policy holder.

Medicare Part D Pharmacy Plan and Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the state-sponsored healthcare options (PPO, POS and HMO) and prescription drug coverage available for people eligible for Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. This notice applies to you and your covered family members who are eligible for Medicare. **If you are actively employed, you do not need to enroll in Medicare prescription drug coverage.**

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare advantage plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The insurance committees have determined that the prescription drug coverage offered under the state-sponsored healthcare options is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered creditable coverage.

Because your existing state-sponsored coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. Beneficiary's leaving state-sponsored coverage may be eligible for a special enrollment period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your state-sponsored coverage, which includes prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with the state-sponsored healthcare options and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact our office for further information. You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the state-sponsored options changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.Medicare.gov
- Call your state health insurance assistance program (see your copy of the *Medicare & You* handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1.800.772.1213 (TTY 1.800.325.0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

CIGNA POS Guest Privileges Program

The CIGNA HealthCare guest privileges program provides healthcare coverage when you are away from home for an extended period. Whether your job takes you to a new city for a few months, or one of your participating family members is away at school.

When away for a temporary period of more than 60 days, but no more than two years, you or your participating family member can inquire with a CIGNA HealthCare customer service representative to see if your are eligible for the guest privileges program. If CIGNA HealthCare has a POS network in the area you are temporarily located and your medical plan design meets that specific states legislation and mandates then you will be eligible to participate. You will not just be covered for emergency care, but for all of your routine and preventive care benefits as well.

To inquire about guest privileges, call CIGNA toll-free at 1.800.244.6224. A customer service representative will discuss your situation and confirm your eligibility for the program. If you are eligible, the representative will take your information and enroll you in the guest privileges program. Further information will then be mailed to your home address.

When You're Ready To Come Home

Call CIGNA HealthCare's customer service number at least one week before you leave your temporary residence. A customer service representative will make sure your coverage will be changed back to your original home location as it was before you left.

Please Remember

To ensure smooth transition of coverage to your guest location or back to your home area when you return, be sure to call customer services at least one week before your move. ***Failure to call may result in benefits being denied.***

The benefit plan available at your guest location will be the same as your home benefit plan. However, in some situations, state mandates may mean a difference in benefits. Call customer services for assistance with any benefits questions.

Children living away from home may participate in the program as long as they continue to meet dependent and/or student eligibility status requirements.

For more information about the guest privileges program — or anytime you have a question about your coverage or benefits — call customer service at the toll-free number listed on the back of your ID card.

Staying In-Network Pays

Under the PPO, POS and PPO Limited healthcare structure, you have the opportunity to use out-of-network providers. However, use of non-network providers will result in substantially more cost to you. Additionally, some services will not be covered out-of-network. If care given is found to be inappropriate and unnecessary, no benefits will be paid and you will be liable for the total cost of the service.

In-network providers have entered into agreements with the insurance companies to accept a pre-negotiated amount as payment in full. They then write off the rest of the standard charge after any applicable deductible or copayment.

You should also pay attention to your benefit structure and obtain referrals when required under your particular healthcare option. Benefits will be denied under any HMO unless you receive services from a designated primary care provider (PCP) or unless you obtain the necessary referral. Additionally, under all HMO options, you should ensure that you are being referred to a participating network provider for benefits to be paid.

Annual Enrollment Transfer Period

October 15 through November 15 is the time frame for this year's annual enrollment transfer period. You will have the opportunity to change health, dental (if available) and life (state plan only) insurance coverages during this time. Changes will be effective January 2008.

The state group insurance program does not have an open enrollment period for health coverage. Annual transfer only provides the opportunity to change your healthcare option for you and your covered dependents. For information on late applicant procedures for individuals who do not elect health coverage during their initial eligibility period, please refer to your insurance handbook.

As there are no contracts which expire during 2007, there will be no changes in the claims administrators for any of the health, dental or life insurance coverages and service areas for the POS and HMO will remain the same. During October, you will receive an updated member handbook for your current health enrollment. Please take time to review this information to familiarize yourself with the specific benefits of your plan.

your health

N E T W O R K

A NEWSLETTER FOR ALL STATE GROUP INSURANCE PROGRAM PARTICIPANTS

July 2007 Volume 15, Number 1

Tennessee Department of Finance and Administration. Authorization No. 317299, July 2007, 150,000 copies. This public document was promulgated at a cost of $0.06 per copy. Contact the editor if you require this publication in an alternative format.

Editor: Alisa Minton, Thirteenth Floor, William R. Snodgrass Tennessee Tower, 312 Eighth Avenue North, Nashville, TN 37243
Phone: 615.741.3590

State of Tennessee
Division of Insurance Administration
Thirteenth Floor
William R. Snodgrass Tennessee Tower
312 Eighth Avenue North
Nashville, TN 37243

Presorted Standard
U.S. Postage
PAID
Nashville, TN
Permit No. 936